

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible Vision exam <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.</i>	Not Applicable \$0 copay	Not Applicable \$0 copay (up to \$30)
Frames <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay (up to \$45)
Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i> <i>Single vision lenses</i> <i>Bifocal lenses</i> <i>Trifocal lenses</i> <i>Lenticular lenses</i> <i>Progressive lenses (standard, premium, select, ultra)</i> <i>Transitions Lenses</i> <i>Standard polycarbonate</i> <i>Factory Scratch Coating</i>	\$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay \$0 copay	\$0 copay (up to \$25) \$0 copay (up to \$45) \$0 copay (up to \$55) \$0 copay (up to \$70) \$0 copay (up to \$40) Not covered Not covered Not covered
Elective contact lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay (up to \$60)
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copay (up to \$210)